WISCONSIN MEDICAID

ADJUSTMENT / RECONSIDERATION REQUEST COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires the information supplied/requested on this form to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The Adjustment/Reconsideration Request is used by both Wisconsin Medicaid and SeniorCare to request an adjustment of an allowed claim (a paid or partially paid claim). Providers may request an adjustment when claim data need to be changed or corrected. After the changes are made to the original claim, the adjusted claim is processed.

Providers cannot adjust a totally denied claim. A claim that was totally denied must be resubmitted after the necessary corrections have been made.

Questions about adjustments and other procedures or policies may be directed to Provider Services at (800) 947-9627 or (608) 221-9883.

The Adjustment/Reconsideration Request is reviewed by Wisconsin Medicaid based on the information provided. Providers may photocopy the Adjustment/Reconsideration Request for their own use. Be as specific as possible when describing how the original claim is to be changed. Providers may also attach a copy of the corrected claim.

INSTRUCTIONS

Type or print clearly.
Enter the following information from the provider's Remittance and Status (R/S) Report or the 835 Health Care Claim Payment/Advice transaction.

SECTION I — BILLING PROVIDER AND RECIPIENT INFORMATION

Element 1 — Name — Billing Provider
Enter the billing provider's name.

Element 2 — Billing Provider's Medicaid Provider Number
Enter the billing provider's eight-digit Medicaid provider number to which the claim was paid.

Element 3 — Name — Recipient
Enter the complete name of the recipient for whom payment was received.

Element 4 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number.

SECTION II — CLAIM INFORMATION

Element 5 — Remittance and Status (R/S) Report Date / Check Issue Date
Enter the date of the R/S Report or the check issue date from the 835 Health Care Claim Payment/Advice transaction showing the paid claim the provider is adjusting.

Element 6 — Internal Control Number / Payer Control Number (15 digits)
Enter the internal control number (ICN) from the R/S Report or the payer claim control number from the 835 of the paid or allowed claim. (When adjusting a previously adjusted claim, use the claim number assigned to the most recently processed claim or adjustment.)

Add a service line(s).
Check if submitting an adjustment to add a service line(s) to a paid or allowed claim. Enter the complete information the provider is requesting to be added to the claim in Elements 7 through 15.

Element 7 — Date(s) of Service
Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service (DOS), enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- When billing for two, three, or four DOS in the same month on the same detail line, enter the first DOS in MM/DD/YY or MM/DD/YYYY format in the "From" field and enter subsequent DOS in the "To" field by listing only the date(s) of the month. For example, for DOS December 1, 8, 15, and 22, 2003, indicate 12/01/03 or 12/01/2003 in the "From" field and indicate 08/15/22 in the "To" field.

It is allowable to enter up to four DOS per line if:

- All DOS are in the same calendar month.
- All services are billed using the same procedure code and modifier(s), if applicable.
- All procedures have the same place of service (POS) code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The billed amount for all procedures is identical.
- The number of services performed on each DOS is identical.
- All procedures have the same family planning indicator, if applicable.
- All procedures have the same emergency indicator, if applicable.

Element 8 — POS
Enter the appropriate two-digit POS code for each service.

Element 9 — Procedure Code / NDC / Revenue Code
Enter the single most appropriate procedure code. Wisconsin Medicaid denies claims received without an appropriate procedure code/NDC/revenue code.

Element 10 — Modifiers 1-4
Enter the appropriate modifier(s).

Element 11 — Billed Amount
Enter the total billed amount for each line item. Providers are to bill Wisconsin Medicaid their usual and customary charge. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to Medicaid benefits.

Element 12 — Unit Quantity
Enter the appropriate number of units for each line item. Always use a decimal (e.g., 2.0 units).

Element 13 — Family Plan
Enter an "F" for each family planning procedure.

Element 14 — EMG
Enter an "E" for each procedure performed as an emergency. If the procedure is not an emergency, leave this element blank.

Element 15 — Performing Provider
Enter the eight-digit Medicaid provider number of the performing provider for each procedure if applicable.

SECTION III — ADJUSTMENT INFORMATION

Element 16 — Reason for Adjustment
Check one of the following boxes indicating the provider's reason for submitting the adjustment:

- *Consultant review requested.* Indicate if there are extenuating circumstances or complicated or new procedures and attach a history and physical operative or anesthesia report.
- *Recoup entire Medicaid payment.* This would include claims billed in error or completely paid by another insurance carrier.
- *Other insurance payment.* Enter the amount paid by the other insurance carrier.
- *Copayment deducted in error.* Indicate if the patient was a nursing home resident on the DOS, or the correct number of covered service days, or if an emergency service was provided.
- *Medicare reconsideration.* Attach both the original and the new Explanation of Medicare Benefits (EOMB), or comparable provider-generated explanation of payment containing the same information.
- *Correct service line.* Provide specific information in the comments section or attach a corrected claim.
- *Other/Comments.* Add any clarifying information not included above.*

Element 17 — Signature — Provider**
Authorized signature of the provider.

Element 18 — Date Signed**
Use either the MM/DD/YY format or the MM/DD/YYYY format.

Element 19 — Claim Form Attached
Indicate if a corrected claim form is attached. Although this is optional, Wisconsin Medicaid encourages providers to attach a corrected claim form when adding additional service lines or correcting information from a previously adjusted claim.

*If either the Submission Clarification Code or the Unit Dose value is being adjusted on a drug claim, both values must be indicated in the comment area, even if one is not being adjusted.
**If the date or signature is missing on the Adjustment/Reconsideration Request Form, the adjustment request will be denied.

The provider should maintain a copy of this form for his or her records.